

AMENDED IN ASSEMBLY JUNE 26, 2014

AMENDED IN SENATE APRIL 21, 2014

**SENATE BILL**

**No. 1034**

---

**Introduced by Senator Monning**

February 14, 2014

---

An act to amend Sections 1357.51, 1357.514, 1357.600, and 1357.614 of, and to repeal and add Sections 1357.506 and 1357.607 of, the Health and Safety Code, and to amend Sections 10198.7, 10753.05, 10755, and 10755.05 of, and to repeal and add Sections 10753.08 and 10755.08 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1034, as amended, Monning. Health care coverage: waiting periods.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect with respect to plan years on or after January 1, 2014. Among other things, PPACA prohibits a group health plan and a health insurance issuer offering group health insurance coverage from applying a waiting period that exceeds 90 days.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a group health care service plan contract and a group health insurance policy, as defined, to apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents.

This bill would prohibit those group contracts and policies from imposing any waiting or affiliation period, as defined, and would make related conforming changes. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

*Existing law provides for the regulation of grandfathered small employer health care service plan contracts and health insurance policies, as defined. Existing law requires that those contracts and policies be fairly and affirmatively renewed and prohibits construing the provisions regulating those contracts and policies from limiting enrollment in a contract or policy to open enrollment periods, as specified. Existing law requires the employer offering the plan to send a written notice to an eligible employee or dependent who fails to enroll during an open enrollment period that he or she may be excluded from coverage for a specified period of time.*

*This bill would instead require the notice to inform the eligible employee or dependent that he or she may be excluded from eligibility for coverage until the next open enrollment period.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

*This bill would incorporate additional changes to Section 10753.05 of the Insurance Code proposed by SB 959 that would become operative if this bill and SB 959 are both enacted and this bill is enacted last.*

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. The Legislature hereby finds and declares the
- 2 following:
- 3 (a) In enacting this legislation, it is the intent of the Legislature
- 4 to prohibit a health care service plan or health insurer offering
- 5 group coverage from imposing a separate waiting or affiliation
- 6 period in addition to any waiting period imposed by an employer
- 7 for a group health plan on an otherwise eligible employee or
- 8 dependent.

1 (b) The Legislature further intends, in enacting this legislation,  
2 to permit a health care service plan or health insurer offering group  
3 coverage to administer a waiting period imposed by a plan sponsor,  
4 as defined in Section 1002 of Title 29 of the United States Code,  
5 if consistent with Section 2708 of the federal Public Health Service  
6 Act (42 U.S.C. Sec. 300gg-7).

7 SEC. 2. Section 1357.51 of the Health and Safety Code is  
8 amended to read:

9 1357.51. (a) A health benefit plan for group coverage shall  
10 not impose any preexisting condition provision or waived  
11 condition provision upon any enrollee.

12 (b) (1) A nongrandfathered health benefit plan for individual  
13 coverage shall not impose any preexisting condition provision or  
14 waived condition provision upon any enrollee.

15 (2) A grandfathered health benefit plan for individual coverage  
16 shall not exclude coverage on the basis of a waived condition  
17 provision or preexisting condition provision for a period greater  
18 than 12 months following the enrollee's effective date of coverage,  
19 nor limit or exclude coverage for a specific enrollee by type of  
20 illness, treatment, medical condition, or accident, except for  
21 satisfaction of a preexisting condition provision or waived  
22 condition provision pursuant to this article. Waivered condition  
23 provisions or preexisting condition provisions contained in  
24 individual grandfathered health benefit plans may relate only to  
25 conditions for which medical advice, diagnosis, care, or treatment,  
26 including use of prescription drugs, was recommended or received  
27 from a licensed health practitioner during the 12 months  
28 immediately preceding the effective date of coverage.

29 (3) If Section 5000A of the Internal Revenue Code, as added  
30 by Section 1501 of PPACA, is repealed or amended to no longer  
31 apply to the individual market, as defined in Section 2791 of the  
32 Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph  
33 (1) shall become inoperative 12 months after the date of that repeal  
34 or amendment and thereafter paragraph (2) shall apply also to  
35 nongrandfathered health benefit plans for individual coverage.

36 (4) In determining whether a preexisting condition provision or  
37 a waived condition provision applies to an individual under this  
38 subdivision, a plan shall credit the time the individual was covered  
39 under creditable coverage, provided that the individual becomes  
40 eligible for coverage under the succeeding plan contract within 62

1 days of termination of prior coverage and applies for coverage  
2 under the succeeding plan within the applicable enrollment period.

3 (c) A health benefit plan for group or individual coverage shall  
4 not impose any waiting or affiliation period.

5 SEC. 3. Section 1357.506 of the Health and Safety Code is  
6 repealed.

7 SEC. 4. Section 1357.506 is added to the Health and Safety  
8 Code, to read:

9 1357.506. A small employer health care service plan contract  
10 shall not impose a preexisting condition provision or a waiting or  
11 affiliation period upon any individual.

12 SEC. 5. Section 1357.514 of the Health and Safety Code is  
13 amended to read:

14 1357.514. In connection with the offering for sale of a small  
15 employer health care service plan contract subject to this article,  
16 each plan shall make a reasonable disclosure, as part of its  
17 solicitation and sales materials, of the following:

18 (a) The provisions concerning the plan's right to change  
19 premium rates and the factors other than provision of services  
20 experience that affect changes in premium rates. The plan shall  
21 disclose that claims experience cannot be used.

22 (b) Provisions relating to the guaranteed issue and renewal of  
23 contracts.

24 (c) A statement that no preexisting condition provisions shall  
25 be allowed.

26 (d) Provisions relating to the small employer's right to apply  
27 for any small employer health care service plan contract written,  
28 issued, or administered by the plan at the time of application for  
29 a new health care service plan contract, or at the time of renewal  
30 of a health care service plan contract, consistent with the  
31 requirements of PPACA.

32 (e) The availability, upon request, of a listing of all the plan's  
33 contracts and benefit plan designs offered, both inside and outside  
34 the Exchange, to small employers, including the rates for each  
35 contract.

36 (f) At the time it offers a contract to a small employer, each plan  
37 shall provide the small employer with a statement of all of its small  
38 employer health care service plan contracts, including the rates  
39 for each plan contract, in the service area in which the employer's  
40 employees and eligible dependents who are to be covered by the

1 plan contract work or reside. For purposes of this subdivision,  
2 plans that are affiliated plans or that are eligible to file a  
3 consolidated income tax return shall be treated as one health plan.

4 (g) Each plan shall do all of the following:

5 (1) Prepare a brochure that summarizes all of its plan contracts  
6 offered to small employers and to make this summary available  
7 to any small employer and to solicitors upon request. The summary  
8 shall include for each contract information on benefits provided,  
9 a generic description of the manner in which services are provided,  
10 such as how access to providers is limited, benefit limitations,  
11 required copayments and deductibles, and a ~~phone~~ *telephone*  
12 number that can be called for more detailed benefit information.  
13 Plans are required to keep the information contained in the brochure  
14 accurate and up to date and, upon updating the brochure, send  
15 copies to solicitors and solicitor firms with whom the plan contracts  
16 to solicit enrollments or subscriptions.

17 (2) For each contract, prepare a more detailed evidence of  
18 coverage and make it available to small employers, solicitors, and  
19 solicitor firms upon request. The evidence of coverage shall contain  
20 all information that a prudent buyer would need to be aware of in  
21 making contract selections.

22 (3) Provide copies of the current summary brochure to all  
23 solicitors and solicitor firms contracting with the plan to solicit  
24 enrollments or subscriptions from small employers.

25 For purposes of this subdivision, plans that are affiliated plans  
26 or that are eligible to file a consolidated income tax return shall  
27 be treated as one health plan.

28 (h) Every solicitor or solicitor firm contracting with one or more  
29 plans to solicit enrollments or subscriptions from small employers  
30 shall do all of the following:

31 (1) When providing information on contracts to a small  
32 employer but making no specific recommendations on particular  
33 plan contracts:

34 (A) Advise the small employer of the plan's obligation to sell  
35 to any small employer any small employer health care service plan  
36 contract, consistent with PPACA, and provide the small employer,  
37 upon request, with the actual rates that would be charged to that  
38 employer for a given contract.

39 (B) Notify the small employer that the solicitor or solicitor firm  
40 will procure rate and benefit information for the small employer

1 on any plan contract offered by a plan whose contract the solicitor  
2 sells.

3 (C) Notify the small employer that upon request the solicitor or  
4 solicitor firm will provide the small employer with the summary  
5 brochure required under paragraph (1) of subdivision (g) for any  
6 plan contract offered by a plan with which the solicitor or solicitor  
7 firm has contracted to solicit enrollments or subscriptions.

8 (D) Notify the small employer of the availability of coverage  
9 and the availability of tax credits for certain employers consistent  
10 with PPACA and state law, including any rules, regulations, or  
11 guidance issued in connection therewith.

12 (2) When recommending a particular benefit plan design or  
13 designs, advise the small employer that, upon request, the agent  
14 will provide the small employer with the brochure required by  
15 paragraph (1) of subdivision (g) containing the benefit plan design  
16 or designs being recommended by the agent or broker.

17 (3) Prior to filing an application for a small employer for a  
18 particular contract:

19 (A) For each of the plan contracts offered by the plan whose  
20 contract the solicitor or solicitor firm is offering, provide the small  
21 employer with the benefit summary required in paragraph (1) of  
22 subdivision (g) and the premium for that particular employer.

23 (B) Notify the small employer that, upon request, the solicitor  
24 or solicitor firm will provide the small employer with an evidence  
25 of coverage brochure for each contract the plan offers.

26 (C) Obtain a signed statement from the small employer  
27 acknowledging that the small employer has received the disclosures  
28 required by this section.

29 SEC. 6. Section 1357.600 of the Health and Safety Code is  
30 amended to read:

31 1357.600. As used in this article, the following definitions shall  
32 apply:

33 (a) “Dependent” means the spouse or registered domestic  
34 partner, or child, of an eligible employee, subject to applicable  
35 terms of the health care service plan contract covering the  
36 employee, and includes dependents of guaranteed association  
37 members if the association elects to include dependents under its  
38 health coverage at the same time it determines its membership  
39 composition pursuant to subdivision (n).

40 (b) “Eligible employee” means either of the following:

1 (1) Any permanent employee who is actively engaged on a  
2 full-time basis in the conduct of the business of the small employer  
3 with a normal workweek of an average of 30 hours per week over  
4 the course of a month, at the small employer's regular places of  
5 business, who has met any statutorily authorized applicable waiting  
6 period requirements. The term includes sole proprietors or partners  
7 of a partnership, if they are actively engaged on a full-time basis  
8 in the small employer's business and included as employees under  
9 a health care service plan contract of a small employer, but does  
10 not include employees who work on a part-time, temporary, or  
11 substitute basis. It includes any eligible employee, as defined in  
12 this paragraph, who obtains coverage through a guaranteed  
13 association. Employees of employers purchasing through a  
14 guaranteed association shall be deemed to be eligible employees  
15 if they would otherwise meet the definition except for the number  
16 of persons employed by the employer. Permanent employees who  
17 work at least 20 hours but not more than 29 hours are deemed to  
18 be eligible employees if all four of the following apply:

19 (A) They otherwise meet the definition of an eligible employee  
20 except for the number of hours worked.

21 (B) The employer offers the employees health coverage under  
22 a health benefit plan.

23 (C) All similarly situated individuals are offered coverage under  
24 the health benefit plan.

25 (D) The employee must have worked at least 20 hours per  
26 normal workweek for at least 50 percent of the weeks in the  
27 previous calendar quarter. The health care service plan may request  
28 any necessary information to document the hours and time period  
29 in question, including, but not limited to, payroll records and  
30 employee wage and tax filings.

31 (2) Any member of a guaranteed association as defined in  
32 subdivision (n).

33 (c) "In force business" means an existing health benefit plan  
34 contract issued by the plan to a small employer.

35 (d) "Late enrollee" means an eligible employee or dependent  
36 who has declined enrollment in a health benefit plan offered by a  
37 small employer at the time of the initial enrollment period provided  
38 under the terms of the health benefit plan and who subsequently  
39 requests enrollment in a health benefit plan of that small employer,  
40 provided that the initial enrollment period shall be a period of at

1 least 30 days. It also means any member of an association that is  
2 a guaranteed association as well as any other person eligible to  
3 purchase through the guaranteed association when that person has  
4 failed to purchase coverage during the initial enrollment period  
5 provided under the terms of the guaranteed association's plan  
6 contract and who subsequently requests enrollment in the plan,  
7 provided that the initial enrollment period shall be a period of at  
8 least 30 days. However, an eligible employee, any other person  
9 eligible for coverage through a guaranteed association pursuant to  
10 subdivision (n), or an eligible dependent shall not be considered  
11 a late enrollee if any of the following is applicable:

12 (1) The individual meets all of the following requirements:

13 (A) He or she was covered under another employer health  
14 benefit plan, the Healthy Families Program, the Access for Infants  
15 and Mothers (AIM) Program, the Medi-Cal program, or coverage  
16 through the California Health Benefit Exchange at the time the  
17 individual was eligible to enroll.

18 (B) He or she certified at the time of the initial enrollment that  
19 coverage under another employer health benefit plan, the Healthy  
20 Families Program, the AIM Program, the Medi-Cal program, or  
21 coverage through the California Health Benefit Exchange was the  
22 reason for declining enrollment, provided that, if the individual  
23 was covered under another employer health benefit plan, including  
24 a plan offered through the California Health Benefit Exchange,  
25 the individual was given the opportunity to make the certification  
26 required by this subdivision and was notified that failure to do so  
27 could result in later treatment as a late enrollee.

28 (C) He or she has lost or will lose coverage under another  
29 employer health benefit plan as a result of termination of  
30 employment of the individual or of a person through whom the  
31 individual was covered as a dependent, change in employment  
32 status of the individual or of a person through whom the individual  
33 was covered as a dependent, termination of the other plan's  
34 coverage, cessation of an employer's contribution toward an  
35 employee's or dependent's coverage, death of the person through  
36 whom the individual was covered as a dependent, legal separation,  
37 or divorce; or he or she has lost or will lose coverage under the  
38 Healthy Families Program, the AIM Program, the Medi-Cal  
39 program, or coverage through the California Health Benefit  
40 Exchange.



(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, Healthy Families Program coverage, or coverage through the California Health Benefit Exchange.

(2) The employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) (A) In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from ~~coverage for no longer than 60 days~~ *eligibility for coverage until the next open enrollment period*, unless the individual meets the criteria specified in paragraph (1), (2), or (3). This exclusion from *eligibility for coverage* shall not be considered a waiting period in violation of Section 1357.51 or 1357.607.

(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from ~~coverage for no longer than 60 days~~ *eligibility for coverage until the next open enrollment period*, unless the individual meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3). This exclusion from *eligibility for coverage* shall not be considered a waiting period in violation of Section 1357.51 or 1357.607.

1 (C) In the case of an employer or person who is not a member  
2 of an association, was eligible to purchase coverage through a  
3 guaranteed association, and did not do so, and would not be eligible  
4 to purchase guaranteed coverage unless purchased through a  
5 guaranteed association, the employer or person can demonstrate  
6 that he or she meets the requirements of subparagraphs (A), (C),  
7 and (D) of paragraph (1), or meets the requirements of paragraph  
8 (2) or (3), or that he or she recently had a change in status that  
9 would make him or her eligible and that application for enrollment  
10 was made within 30 days of the change.

11 (5) The individual is an employee or dependent who meets the  
12 criteria described in paragraph (1) and was under a COBRA  
13 continuation provision and the coverage under that provision has  
14 been exhausted. For purposes of this section, the definition of  
15 “COBRA” set forth in subdivision (e) of Section 1373.621 shall  
16 apply.

17 (6) The individual is a dependent of an enrolled eligible  
18 employee who has lost or will lose his or her coverage under the  
19 Healthy Families Program, the AIM Program, the Medi-Cal  
20 program, or a health benefit plan offered through the California  
21 Health Benefit Exchange and requests enrollment within 60 days  
22 after termination of that coverage.

23 (7) The individual is an eligible employee who previously  
24 declined coverage under an employer health benefit plan, including  
25 a plan offered through the California Health Benefit Exchange,  
26 and who has subsequently acquired a dependent who would be  
27 eligible for coverage as a dependent of the employee through  
28 marriage, birth, adoption, or placement for adoption, and who  
29 enrolls for coverage under that employer health benefit plan on  
30 his or her behalf and on behalf of his or her dependent within 30  
31 days following the date of marriage, birth, adoption, or placement  
32 for adoption, in which case the effective date of coverage shall be  
33 the first day of the month following the date the completed request  
34 for enrollment is received in the case of marriage, or the date of  
35 birth, or the date of adoption or placement for adoption, whichever  
36 applies. Notice of the special enrollment rights contained in this  
37 paragraph shall be provided by the employer to an employee at or  
38 before the time the employee is offered an opportunity to enroll  
39 in plan coverage.

1 (8) The individual is an eligible employee who has declined  
2 coverage for himself or herself or his or her dependents during a  
3 previous enrollment period because his or her dependents were  
4 covered by another employer health benefit plan, including a plan  
5 offered through the California Health Benefit Exchange, at the  
6 time of the previous enrollment period. That individual may enroll  
7 himself or herself or his or her dependents for plan coverage during  
8 a special open enrollment opportunity if his or her dependents have  
9 lost or will lose coverage under that other employer health benefit  
10 plan. The special open enrollment opportunity shall be requested  
11 by the employee not more than 30 days after the date that the other  
12 health coverage is exhausted or terminated. Upon enrollment,  
13 coverage shall be effective not later than the first day of the first  
14 calendar month beginning after the date the request for enrollment  
15 is received. Notice of the special enrollment rights contained in  
16 this paragraph shall be provided by the employer to an employee  
17 at or before the time the employee is offered an opportunity to  
18 enroll in plan coverage.

19 (e) “Preexisting condition provision” means a contract provision  
20 that excludes coverage for charges or expenses incurred during a  
21 specified period following the enrollee’s effective date of coverage,  
22 as to a condition for which medical advice, diagnosis, care, or  
23 treatment was recommended or received during a specified period  
24 immediately preceding the effective date of coverage. No health  
25 care service plan shall limit or exclude coverage for any individual  
26 based on a preexisting condition whether or not any medical advice,  
27 diagnosis, care, or treatment was recommended or received before  
28 that date.

29 (f) “Creditable coverage” means:

30 (1) Any individual or group policy, contract, or program that is  
31 written or administered by a disability insurer, health care service  
32 plan, fraternal benefits society, self-insured employer plan, or any  
33 other entity, in this state or elsewhere, and that arranges or provides  
34 medical, hospital, and surgical coverage not designed to supplement  
35 other private or governmental plans. The term includes continuation  
36 or conversion coverage but does not include accident only, credit,  
37 coverage for onsite medical clinics, disability income, Medicare  
38 supplement, long-term care, dental, vision, coverage issued as a  
39 supplement to liability insurance, insurance arising out of a  
40 workers’ compensation or similar law, automobile medical payment

1 insurance, or insurance under which benefits are payable with or  
2 without regard to fault and that is statutorily required to be  
3 contained in any liability insurance policy or equivalent  
4 self-insurance.

5 (2) The Medicare Program pursuant to Title XVIII of the federal  
6 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

7 (3) The Medicaid Program pursuant to Title XIX of the federal  
8 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

9 (4) Any other publicly sponsored program, provided in this state  
10 or elsewhere, of medical, hospital, and surgical care.

11 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
12 (Civilian Health and Medical Program of the Uniformed Services  
13 (CHAMPUS)).

14 (6) A medical care program of the Indian Health Service or of  
15 a tribal organization.

16 (7) A health plan offered under 5 U.S.C. Chapter 89  
17 (commencing with Section 8901) (Federal Employees Health  
18 Benefits Program (FEHBP)).

19 (8) A public health plan as defined in federal regulations  
20 authorized by Section 2701(c)(1)(I) of the Public Health Service  
21 Act, as amended by Public Law 104-191, the Health Insurance  
22 Portability and Accountability Act of 1996.

23 (9) A health benefit plan under Section 5(e) of the Peace Corps  
24 Act (22 U.S.C. Sec. 2504(e)).

25 (10) Any other creditable coverage as defined by subsection (c)  
26 of Section 2704 of Title XXVII of the federal Public Health Service  
27 Act (42 U.S.C. Sec. 300gg-3(c)).

28 (g) “Rating period” means the period for which premium rates  
29 established by a plan are in effect and shall be no less than 12  
30 months from the date of issuance or renewal of the health care  
31 service plan contract.

32 (h) “Risk adjusted employee risk rate” means the rate determined  
33 for an eligible employee of a small employer in a particular risk  
34 category after applying the risk adjustment factor.

35 (i) “Risk adjustment factor” means the percentage adjustment  
36 to be applied equally to each standard employee risk rate for a  
37 particular small employer, based upon any expected deviations  
38 from standard cost of services. This factor may not be more than  
39 110 percent or less than 90 percent.

1 (j) “Risk category” means the following characteristics of an  
2 eligible employee: age, geographic region, and family composition  
3 of the employee, plus the health benefit plan selected by the small  
4 employer.

5 (1) No more than the following age categories may be used in  
6 determining premium rates:

7 Under 30

8 30–39

9 40–49

10 50–54

11 55–59

12 60–64

13 65 and over

14 However, for the 65 and over age category, separate premium  
15 rates may be specified depending upon whether coverage under  
16 the plan contract will be primary or secondary to benefits provided  
17 by the Medicare Program pursuant to Title XVIII of the federal  
18 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

19 (2) Small employer health care service plans shall base rates to  
20 small employers using no more than the following family size  
21 categories:

22 (A) Single.

23 (B) Married couple or registered domestic partners.

24 (C) One adult and child or children.

25 (D) Married couple or registered domestic partners and child  
26 or children.

27 (3) (A) In determining rates for small employers, a plan that  
28 operates statewide shall use no more than nine geographic regions  
29 in the state, have no region smaller than an area in which the first  
30 three digits of all its ZIP Codes are in common within a county,  
31 and divide no county into more than two regions. Plans shall be  
32 deemed to be operating statewide if their coverage area includes  
33 90 percent or more of the state’s population. Geographic regions  
34 established pursuant to this section shall, as a group, cover the  
35 entire state, and the area encompassed in a geographic region shall  
36 be separate and distinct from areas encompassed in other  
37 geographic regions. Geographic regions may be noncontiguous.

38 (B) (i) In determining rates for small employers, a plan that  
39 does not operate statewide shall use no more than the number of  
40 geographic regions in the state that is determined by the following

1 formula: the population, as determined in the last federal census,  
2 of all counties that are included in their entirety in a plan's service  
3 area divided by the total population of the state, as determined in  
4 the last federal census, multiplied by nine. The resulting number  
5 shall be rounded to the nearest whole integer. No region may be  
6 smaller than an area in which the first three digits of all its ZIP  
7 Codes are in common within a county and no county may be  
8 divided into more than two regions. The area encompassed in a  
9 geographic region shall be separate and distinct from areas  
10 encompassed in other geographic regions. Geographic regions  
11 may be noncontiguous. No plan shall have less than one geographic  
12 area.

13 (ii) If the formula in clause (i) results in a plan that operates in  
14 more than one county having only one geographic region, then the  
15 formula in clause (i) shall not apply and the plan may have two  
16 geographic regions, provided that no county is divided into more  
17 than one region.

18 Nothing in this section shall be construed to require a plan to  
19 establish a new service area or to offer health coverage on a  
20 statewide basis, outside of the plan's existing service area.

21 (k) (1) "Small employer" means any of the following:

22 (A) For plan years commencing on or after January 1, 2014,  
23 and on or before December 31, 2015, any person, firm, proprietary  
24 or nonprofit corporation, partnership, public agency, or association  
25 that is actively engaged in business or service, that, on at least 50  
26 percent of its working days during the preceding calendar quarter  
27 or preceding calendar year, employed at least one, but no more  
28 than 50, eligible employees, the majority of whom were employed  
29 within this state, that was not formed primarily for purposes of  
30 buying health care service plan contracts, and in which a bona fide  
31 employer-employee relationship exists. For plan years commencing  
32 on or after January 1, 2016, any person, firm, proprietary or  
33 nonprofit corporation, partnership, public agency, or association  
34 that is actively engaged in business or service, that, on at least 50  
35 percent of its working days during the preceding calendar quarter  
36 or preceding calendar year, employed at least one, but no more  
37 than 100, eligible employees, the majority of whom were employed  
38 within this state, that was not formed primarily for purposes of  
39 buying health care service plan contracts, and in which a bona fide  
40 employer-employee relationship exists. In determining whether

1 to apply the calendar quarter or calendar year test, a health care  
2 service plan shall use the test that ensures eligibility if only one  
3 test would establish eligibility. In determining the number of  
4 eligible employees, companies that are affiliated companies and  
5 that are eligible to file a combined tax return for purposes of state  
6 taxation shall be considered one employer. Subsequent to the  
7 issuance of a health care service plan contract to a small employer  
8 pursuant to this article, and for the purpose of determining  
9 eligibility, the size of a small employer shall be determined  
10 annually. Except as otherwise specifically provided in this article,  
11 provisions of this article that apply to a small employer shall  
12 continue to apply until the plan contract anniversary following the  
13 date the employer no longer meets the requirements of this  
14 definition. It includes any small employer as defined in this  
15 subparagraph who purchases coverage through a guaranteed  
16 association, and any employer purchasing coverage for employees  
17 through a guaranteed association. This subparagraph shall be  
18 implemented to the extent consistent with PPACA, except that the  
19 minimum requirement of one employee shall be implemented only  
20 to the extent required by PPACA.

21 (B) Any guaranteed association, as defined in subdivision (m),  
22 that purchases health coverage for members of the association.

23 (2) For plan years commencing on or after January 1, 2014, the  
24 definition of an employer, for purposes of determining whether  
25 an employer with one employee shall include sole proprietors,  
26 certain owners of “S” corporations, or other individuals, shall be  
27 consistent with Section 1304 of PPACA.

28 (l) “Standard employee risk rate” means the rate applicable to  
29 an eligible employee in a particular risk category in a small  
30 employer group.

31 (m) “Guaranteed association” means a nonprofit organization  
32 comprised of a group of individuals or employers who associate  
33 based solely on participation in a specified profession or industry,  
34 accepting for membership any individual or employer meeting its  
35 membership criteria, and that (1) includes one or more small  
36 employers as defined in subparagraph (A) of paragraph (1) of  
37 subdivision (k), (2) does not condition membership directly or  
38 indirectly on the health or claims history of any person, (3) uses  
39 membership dues solely for and in consideration of the membership  
40 and membership benefits, except that the amount of the dues shall

1 not depend on whether the member applies for or purchases  
2 insurance offered to the association, (4) is organized and  
3 maintained in good faith for purposes unrelated to insurance, (5)  
4 has been in active existence on January 1, 1992, and for at least  
5 five years prior to that date, (6) has included health insurance as  
6 a membership benefit for at least five years prior to January 1,  
7 1992, (7) has a constitution and bylaws, or other analogous  
8 governing documents that provide for election of the governing  
9 board of the association by its members, (8) offers any plan contract  
10 that is purchased to all individual members and employer members  
11 in this state, (9) includes any member choosing to enroll in the  
12 plan contracts offered to the association provided that the member  
13 has agreed to make the required premium payments, and (10)  
14 covers at least 1,000 persons with the health care service plan with  
15 which it contracts. The requirement of 1,000 persons may be met  
16 if component chapters of a statewide association contracting  
17 separately with the same carrier cover at least 1,000 persons in the  
18 aggregate.

19 This subdivision applies regardless of whether a contract issued  
20 by a plan is with an association, or a trust formed for or sponsored  
21 by an association, to administer benefits for association members.

22 For purposes of this subdivision, an association formed by a  
23 merger of two or more associations after January 1, 1992, and  
24 otherwise meeting the criteria of this subdivision shall be deemed  
25 to have been in active existence on January 1, 1992, if its  
26 predecessor organizations had been in active existence on January  
27 1, 1992, and for at least five years prior to that date and otherwise  
28 met the criteria of this subdivision.

29 (n) "Members of a guaranteed association" means any individual  
30 or employer meeting the association's membership criteria if that  
31 person is a member of the association and chooses to purchase  
32 health coverage through the association. At the association's  
33 discretion, it also may include employees of association members,  
34 association staff, retired members, retired employees of members,  
35 and surviving spouses and dependents of deceased members.  
36 However, if an association chooses to include these persons as  
37 members of the guaranteed association, the association shall make  
38 that election in advance of purchasing a plan contract. Health care  
39 service plans may require an association to adhere to the  
40 membership composition it selects for up to 12 months.



1 (o) “Affiliation period” means a period that, under the terms of  
2 the health care service plan contract, must expire before health  
3 care services under the contract become effective.

4 (p) “Grandfathered small employer health care service plan  
5 contract” means a small employer health care service plan contract  
6 that constitutes a grandfathered health plan.

7 (q) “Grandfathered health plan” has the meaning set forth in  
8 Section 1251 of PPACA.

9 (r) “Nongrandfathered small employer health care service plan  
10 contract” means a small employer health care service plan contract  
11 that is not a grandfathered health plan.

12 (s) “Plan year” has the meaning set forth in Section 144.103 of  
13 Title 45 of the Code of Federal Regulations.

14 (t) “PPACA” means the federal Patient Protection and  
15 Affordable Care Act (Public Law 111-148), as amended by the  
16 federal Health Care and Education Reconciliation Act of 2010  
17 (Public Law 111-152), and any rules, regulations, or guidance  
18 issued thereunder.

19 (u) “Registered domestic partner” means a person who has  
20 established a domestic partnership as described in Section 297 of  
21 the Family Code.

22 (v) “Small employer health care service plan contract” means  
23 a health care service plan contract issued to a small employer.

24 (w) “Waiting period” means a period that is required to pass  
25 with respect to an employee before the employee is eligible to be  
26 covered for benefits under the terms of the contract.

27 SEC. 7. Section 1357.607 of the Health and Safety Code is  
28 repealed.

29 SEC. 8. Section 1357.607 is added to the Health and Safety  
30 Code, to read:

31 1357.607. A small employer health care service plan contract  
32 shall not impose a preexisting condition provision or a waiting or  
33 affiliation period upon any individual.

34 SEC. 9. Section 1357.614 of the Health and Safety Code is  
35 amended to read:

36 1357.614. In connection with the renewal of a grandfathered  
37 small employer health care service plan contract, each plan shall  
38 make a reasonable disclosure, as part of its solicitation and sales  
39 materials, of the following:

1 (a) The extent to which premium rates for a specified small  
2 employer are established or adjusted in part based upon the actual  
3 or expected variation in service costs of the employees and  
4 dependents of the small employer.

5 (b) The provisions concerning the plan's right to change  
6 premium rates and the factors other than provision of services  
7 experience that affect changes in premium rates.

8 (c) Provisions relating to the guaranteed issue and renewal of  
9 contracts.

10 (d) Provisions relating to the effect of any waiting or affiliation  
11 provision.

12 (e) Provisions relating to the small employer's right to apply  
13 for any nongrandfathered small employer health care service plan  
14 contract written, issued, or administered by the plan at the time of  
15 application for a new health care service plan contract, or at the  
16 time of renewal of a health care service plan contract, consistent  
17 with the requirements of PPACA.

18 (f) The availability, upon request, of a listing of all the plan's  
19 nongrandfathered small employer health care service plan contracts  
20 and benefit plan designs offered, both inside and outside the  
21 California Health Benefit Exchange, including the rates for each  
22 contract.

23 (g) At the time it renews a grandfathered small employer health  
24 care service plan contract, each plan shall provide the small  
25 employer with a statement of all of its nongrandfathered small  
26 employer health care service plan contracts, including the rates  
27 for each plan contract, in the service area in which the employer's  
28 employees and eligible dependents who are to be covered by the  
29 plan contract work or reside. For purposes of this subdivision,  
30 plans that are affiliated plans or that are eligible to file a  
31 consolidated income tax return shall be treated as one health plan.

32 (h) Each plan shall do all of the following:

33 (1) Prepare a brochure that summarizes all of its small employer  
34 health care service plan contracts and to make this summary  
35 available to any small employer and to solicitors upon request.  
36 The summary shall include for each contract information on  
37 benefits provided, a generic description of the manner in which  
38 services are provided, such as how access to providers is limited,  
39 benefit limitations, required copayments and deductibles, standard  
40 employee risk rates, and a ~~phone~~ *telephone* number that can be

1 called for more detailed benefit information. Plans are required to  
2 keep the information contained in the brochure accurate and up to  
3 date and, upon updating the brochure, send copies to solicitors and  
4 solicitor firms with which the plan contracts to solicit enrollments  
5 or subscriptions.

6 (2) For each contract, prepare a more detailed evidence of  
7 coverage and make it available to small employers, solicitors, and  
8 solicitor firms upon request. The evidence of coverage shall contain  
9 all information that a prudent buyer would need to be aware of in  
10 making contract selections.

11 (3) Provide to small employers and solicitors, upon request, for  
12 any given small employer the sum of the standard employee risk  
13 rates and the sum of the risk adjusted employee risk rates. When  
14 requesting this information, small employers, solicitors, and  
15 solicitor firms shall provide the plan with the information the plan  
16 needs to determine the small employer's risk adjusted employee  
17 risk rate.

18 (4) Provide copies of the current summary brochure to all  
19 solicitors and solicitor firms contracting with the plan to solicit  
20 enrollments or subscriptions from small employers.

21 For purposes of this subdivision, plans that are affiliated plans  
22 or that are eligible to file a consolidated income tax return shall  
23 be treated as one health plan.

24 SEC. 10. Section 10198.7 of the Insurance Code is amended  
25 to read:

26 10198.7. (a) A health benefit plan for group coverage shall  
27 not impose any preexisting condition provision or waived  
28 condition provision upon any individual.

29 (b) (1) A nongrandfathered health benefit plan for individual  
30 coverage shall not impose any preexisting condition provision or  
31 waived condition provision upon any individual.

32 (2) A grandfathered health benefit plan for individual coverage  
33 shall not exclude coverage on the basis of a waived condition  
34 provision or preexisting condition provision for a period greater  
35 than 12 months following the individual's effective date of  
36 coverage, nor limit or exclude coverage for a specific insured by  
37 type of illness, treatment, medical condition, or accident, except  
38 for satisfaction of a preexisting condition provision or waived  
39 condition provision pursuant to this article. Waivered condition  
40 provisions or preexisting condition provisions contained in

1 individual grandfathered health benefit plans may relate only to  
2 conditions for which medical advice, diagnosis, care, or treatment,  
3 including use of prescription drugs, was recommended or received  
4 from a licensed health practitioner during the 12 months  
5 immediately preceding the effective date of coverage.

6 (3) If Section 5000A of the Internal Revenue Code, as added  
7 by Section 1501 of PPACA, is repealed or amended to no longer  
8 apply to the individual market, as defined in Section 2791 of the  
9 Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph  
10 (1) shall become inoperative 12 months after the date of that repeal  
11 or amendment and thereafter paragraph (2) shall apply also to  
12 nongrandfathered health benefit plans for individual coverage.

13 (4) In determining whether a preexisting condition provision or  
14 a waived condition provision applies to an individual under this  
15 subdivision, a health benefit plan shall credit the time the individual  
16 was covered under creditable coverage, provided that the individual  
17 becomes eligible for coverage under the succeeding health benefit  
18 plan within 62 days of termination of prior coverage and applies  
19 for coverage under the succeeding plan within the applicable  
20 enrollment period.

21 (c) A health benefit plan for group or individual coverage shall  
22 not impose a waiting period.

23 SEC. 11. Section 10753.05 of the Insurance Code is amended  
24 to read:

25 10753.05. (a) No group or individual policy or contract or  
26 certificate of group insurance or statement of group coverage  
27 providing benefits to employees of small employers as defined in  
28 this chapter shall be issued or delivered by a carrier subject to the  
29 jurisdiction of the commissioner regardless of the situs of the  
30 contract or master policyholder or of the domicile of the carrier  
31 nor, except as otherwise provided in Sections 10270.91 and  
32 10270.92, shall a carrier provide coverage subject to this chapter  
33 until a copy of the form of the policy, contract, certificate, or  
34 statement of coverage is filed with and approved by the  
35 commissioner in accordance with Sections 10290 and 10291, and  
36 the carrier has complied with the requirements of Section 10753.17.

37 (b) (1) On and after October 1, 2013, each carrier shall fairly  
38 and affirmatively offer, market, and sell all of the carrier's health  
39 benefit plans that are sold to, offered through, or sponsored by,  
40 small employers or associations that include small employers for

1 plan years on or after January 1, 2014, to all small employers in  
2 each geographic region in which the carrier makes coverage  
3 available or provides benefits.

4 (2) A carrier that offers qualified health plans through the  
5 Exchange shall be deemed to be in compliance with paragraph (1)  
6 with respect to health benefit plans offered through the Exchange  
7 in those geographic regions in which the carrier offers plans  
8 through the Exchange.

9 (3) A carrier shall provide enrollment periods consistent with  
10 PPACA and described in Section 155.725 of Title 45 of the Code  
11 of Federal Regulations. Commencing January 1, 2014, a carrier  
12 shall provide special enrollment periods consistent with the special  
13 enrollment periods described in Section 10965.3, to the extent  
14 permitted by PPACA, except for the triggering events identified  
15 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
16 the Code of Federal Regulations with respect to health benefit  
17 plans offered through the Exchange.

18 (4) Nothing in this section shall be construed to require an  
19 association, or a trust established and maintained by an association  
20 to receive a master insurance policy issued by an admitted insurer  
21 and to administer the benefits thereof solely for association  
22 members, to offer, market, or sell a benefit plan design to those  
23 who are not members of the association. However, if the  
24 association markets, offers, or sells a benefit plan design to those  
25 who are not members of the association it is subject to the  
26 requirements of this section. This shall apply to an association that  
27 otherwise meets the requirements of paragraph (8) formed by  
28 merger of two or more associations after January 1, 1992, if the  
29 predecessor organizations had been in active existence on January  
30 1, 1992, and for at least five years prior to that date and met the  
31 requirements of paragraph (5).

32 (5) A carrier which (A) effective January 1, 1992, and at least  
33 20 years prior to that date, markets, offers, or sells benefit plan  
34 designs only to all members of one association and (B) does not  
35 market, offer, or sell any other individual, selected group, or group  
36 policy or contract providing medical, hospital, and surgical benefits  
37 shall not be required to market, offer, or sell to those who are not  
38 members of the association. However, if the carrier markets, offers,  
39 or sells any benefit plan design or any other individual, selected  
40 group, or group policy or contract providing medical, hospital, and

1 surgical benefits to those who are not members of the association  
2 it is subject to the requirements of this section.

3 (6) Each carrier that sells health benefit plans to members of  
4 one association pursuant to paragraph (5) shall submit an annual  
5 statement to the commissioner which states that the carrier is selling  
6 health benefit plans pursuant to paragraph (5) and which, for the  
7 one association, lists all the information required by paragraph (7).

8 (7) Each carrier that sells health benefit plans to members of  
9 any association shall submit an annual statement to the  
10 commissioner which lists each association to which the carrier  
11 sells health benefit plans, the industry or profession which is served  
12 by the association, the association's membership criteria, a list of  
13 officers, the state in which the association is organized, and the  
14 site of its principal office.

15 (8) For purposes of paragraphs (4) and (6), an association is a  
16 nonprofit organization comprised of a group of individuals or  
17 employers who associate based solely on participation in a  
18 specified profession or industry, accepting for membership any  
19 individual or small employer meeting its membership criteria,  
20 which do not condition membership directly or indirectly on the  
21 health or claims history of any person, which uses membership  
22 dues solely for and in consideration of the membership and  
23 membership benefits, except that the amount of the dues shall not  
24 depend on whether the member applies for or purchases insurance  
25 offered by the association, which is organized and maintained in  
26 good faith for purposes unrelated to insurance, which has been in  
27 active existence on January 1, 1992, and at least five years prior  
28 to that date, which has a constitution and bylaws, or other  
29 analogous governing documents which provide for election of the  
30 governing board of the association by its members, which has  
31 contracted with one or more carriers to offer one or more health  
32 benefit plans to all individual members and small employer  
33 members in this state. Health coverage through an association that  
34 is not related to employment shall be considered individual  
35 coverage pursuant to Section 144.102(c) of Title 45 of the Code  
36 of Federal Regulations.

37 (c) On and after October 1, 2013, each carrier shall make  
38 available to each small employer all health benefit plans that the  
39 carrier offers or sells to small employers or to associations that  
40 include small employers for plan years on or after January 1, 2014.

1 Notwithstanding subdivision (c) of Section 10753, for purposes  
2 of this subdivision, companies that are affiliated companies or that  
3 are eligible to file a consolidated income tax return shall be treated  
4 as one carrier.

5 (d) Each carrier shall do all of the following:

6 (1) Prepare a brochure that summarizes all of its health benefit  
7 plans and make this summary available to small employers, agents,  
8 and brokers upon request. The summary shall include for each  
9 plan information on benefits provided, a generic description of the  
10 manner in which services are provided, such as how access to  
11 providers is limited, benefit limitations, required copayments and  
12 deductibles, and a telephone number that can be called for more  
13 detailed benefit information. Carriers are required to keep the  
14 information contained in the brochure accurate and up to date, and,  
15 upon updating the brochure, send copies to agents and brokers  
16 representing the carrier. Any entity that provides administrative  
17 services only with regard to a health benefit plan written or issued  
18 by another carrier shall not be required to prepare a summary  
19 brochure which includes that benefit plan.

20 (2) For each health benefit plan, prepare a more detailed  
21 evidence of coverage and make it available to small employers,  
22 agents, and brokers upon request. The evidence of coverage shall  
23 contain all information that a prudent buyer would need to be aware  
24 of in making selections of benefit plan designs. An entity that  
25 provides administrative services only with regard to a health benefit  
26 plan written or issued by another carrier shall not be required to  
27 prepare an evidence of coverage for that health benefit plan.

28 (3) Provide copies of the current summary brochure to all agents  
29 or brokers who represent the carrier and, upon updating the  
30 brochure, send copies of the updated brochure to agents and brokers  
31 representing the carrier for the purpose of selling health benefit  
32 plans.

33 (4) Notwithstanding subdivision (c) of Section 10753, for  
34 purposes of this subdivision, companies that are affiliated  
35 companies or that are eligible to file a consolidated income tax  
36 return shall be treated as one carrier.

37 (e) Every agent or broker representing one or more carriers for  
38 the purpose of selling health benefit plans to small employers shall  
39 do all of the following:

1 (1) When providing information on a health benefit plan to a  
2 small employer but making no specific recommendations on  
3 particular benefit plan designs:

4 (A) Advise the small employer of the carrier's obligation to sell  
5 to any small employer any of the health benefit plans it offers to  
6 small employers, consistent with PPACA, and provide them, upon  
7 request, with the actual rates that would be charged to that  
8 employer for a given health benefit plan.

9 (B) Notify the small employer that the agent or broker will  
10 procure rate and benefit information for the small employer on  
11 any health benefit plan offered by a carrier for whom the agent or  
12 broker sells health benefit plans.

13 (C) Notify the small employer that, upon request, the agent or  
14 broker will provide the small employer with the summary brochure  
15 required in paragraph (1) of subdivision (d) for any benefit plan  
16 design offered by a carrier whom the agent or broker represents.

17 (D) Notify the small employer of the availability of coverage  
18 and the availability of tax credits for certain employers consistent  
19 with PPACA and state law, including any rules, regulations, or  
20 guidance issued in connection therewith.

21 (2) When recommending a particular benefit plan design or  
22 designs, advise the small employer that, upon request, the agent  
23 will provide the small employer with the brochure required by  
24 paragraph (1) of subdivision (d) containing the benefit plan design  
25 or designs being recommended by the agent or broker.

26 (3) Prior to filing an application for a small employer for a  
27 particular health benefit plan:

28 (A) For each of the health benefit plans offered by the carrier  
29 whose health benefit plan the agent or broker is presenting, provide  
30 the small employer with the benefit summary required in paragraph  
31 (1) of subdivision (d) and the premium for that particular employer.

32 (B) Notify the small employer that, upon request, the agent or  
33 broker will provide the small employer with an evidence of  
34 coverage brochure for each health benefit plan the carrier offers.

35 (C) Obtain a signed statement from the small employer  
36 acknowledging that the small employer has received the disclosures  
37 required by this paragraph and Section 10753.16.

38 (f) No carrier, agent, or broker shall induce or otherwise  
39 encourage a small employer to separate or otherwise exclude an  
40 eligible employee from a health benefit plan which, in the case of



1 an eligible employee meeting the definition in paragraph (1) of  
2 subdivision (f) of Section 10753, is provided in connection with  
3 the employee's employment or which, in the case of an eligible  
4 employee as defined in paragraph (2) of subdivision (f) of Section  
5 10753, is provided in connection with a guaranteed association.

6 (g) No carrier shall reject an application from a small employer  
7 for a health benefit plan provided:

8 (1) The small employer as defined by subparagraph (A) of  
9 paragraph (1) of subdivision (q) of Section 10753 offers health  
10 benefits to 100 percent of its eligible employees as defined in  
11 paragraph (1) of subdivision (f) of Section 10753. Employees who  
12 waive coverage on the grounds that they have other group coverage  
13 shall not be counted as eligible employees.

14 (2) The small employer agrees to make the required premium  
15 payments.

16 (h) No carrier or agent or broker shall, directly or indirectly,  
17 engage in the following activities:

18 (1) Encourage or direct small employers to refrain from filing  
19 an application for coverage with a carrier because of the health  
20 status, claims experience, industry, occupation, or geographic  
21 location within the carrier's approved service area of the small  
22 employer or the small employer's employees.

23 (2) Encourage or direct small employers to seek coverage from  
24 another carrier because of the health status, claims experience,  
25 industry, occupation, or geographic location within the carrier's  
26 approved service area of the small employer or the small  
27 employer's employees.

28 (3) Employ marketing practices or benefit designs that will have  
29 the effect of discouraging the enrollment of individuals with  
30 significant health needs or discriminate based on the individual's  
31 race, color, national origin, present or predicted disability, age,  
32 sex, gender identity, sexual orientation, expected length of life,  
33 degree of medical dependency, quality of life, or other health  
34 conditions.

35 This subdivision shall be enforced in the same manner as Section  
36 790.03, including through Sections 790.035 and 790.05.

37 (i) No carrier shall, directly or indirectly, enter into any contract,  
38 agreement, or arrangement with an agent or broker that provides  
39 for or results in the compensation paid to an agent or broker for a  
40 health benefit plan to be varied because of the health status, claims

1 experience, industry, occupation, or geographic location of the  
2 small employer or the small employer's employees. This  
3 subdivision shall not apply with respect to a compensation  
4 arrangement that provides compensation to an agent or broker on  
5 the basis of percentage of premium, provided that the percentage  
6 shall not vary because of the health status, claims experience,  
7 industry, occupation, or geographic area of the small employer.

8 (j) (1) A health benefit plan offered to a small employer, as  
9 defined in Section 1304(b) of PPACA and in Section 10753, shall  
10 not establish rules for eligibility, including continued eligibility,  
11 of an individual, or dependent of an individual, to enroll under the  
12 terms of the plan based on any of the following health status-related  
13 factors:

14 (A) Health status.

15 (B) Medical condition, including physical and mental illnesses.

16 (C) Claims experience.

17 (D) Receipt of health care.

18 (E) Medical history.

19 (F) Genetic information.

20 (G) Evidence of insurability, including conditions arising out  
21 of acts of domestic violence.

22 (H) Disability.

23 (I) Any other health status-related factor as determined by any  
24 federal regulations, rules, or guidance issued pursuant to Section  
25 2705 of the federal Public Health Service Act.

26 (2) Notwithstanding Section 10291.5, a carrier shall not require  
27 an eligible employee or dependent to fill out a health assessment  
28 or medical questionnaire prior to enrollment under a health benefit  
29 plan. A carrier shall not acquire or request information that relates  
30 to a health status-related factor from the applicant or his or her  
31 dependent or any other source prior to enrollment of the individual.

32 (k) (1) A carrier shall consider as a single risk pool for rating  
33 purposes in the small employer market the claims experience of  
34 all insureds in all nongrandfathered small employer health benefit  
35 plans offered by the carrier in this state, whether offered as health  
36 care service plan contracts or health insurance policies, including  
37 those insureds and enrollees who enroll in coverage through the  
38 Exchange and insureds and enrollees covered by the carrier outside  
39 of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a carrier shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the carrier's nongrandfathered health benefit plans shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A carrier may vary premium rates for a particular nongrandfathered health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for health benefit plans that offer those benefits in addition to essential health benefits.

(D) Administrative costs, excluding any user fees required by the Exchange.

(E) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(I) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case, 12 months after the repeal, carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

(2) Paragraph (3) of subdivision (b) of this section shall remain operative as it relates to health benefit plans offered through the Exchange.

*SEC. 11.5. Section 10753.05 of the Insurance Code is amended to read:*

10753.05. (a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10753.17.

(b) (1) On and after October 1, 2013, each carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are sold to, offered through, or sponsored by, small employers or associations that include small employers for plan years on or after January 1, 2014, to all small employers in each geographic region in which the carrier makes coverage available or provides benefits.

(2) A carrier that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to health benefit plans offered through the Exchange in those geographic regions in which the carrier offers plans through the Exchange.

(3) A carrier shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Commencing January 1, 2014, a carrier

1 shall provide special enrollment periods consistent with the special  
2 enrollment periods described in Section 10965.3, to the extent  
3 permitted by PPACA, except for the triggering events identified  
4 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
5 the Code of Federal Regulations with respect to health benefit  
6 plans offered through the Exchange.

7 (4) Nothing in this section shall be construed to require an  
8 association, or a trust established and maintained by an association  
9 to receive a master insurance policy issued by an admitted insurer  
10 and to administer the benefits thereof solely for association  
11 members, to offer, market, or sell a benefit plan design to those  
12 who are not members of the association. However, if the  
13 association markets, offers, or sells a benefit plan design to those  
14 who are not members of the association it is subject to the  
15 requirements of this section. This shall apply to an association that  
16 otherwise meets the requirements of paragraph (8) formed by  
17 merger of two or more associations after January 1, 1992, if the  
18 predecessor organizations had been in active existence on January  
19 1, 1992, and for at least five years prior to that date and met the  
20 requirements of paragraph (5).

21 (5) A carrier which (A) effective January 1, 1992, and at least  
22 20 years prior to that date, markets, offers, or sells benefit plan  
23 designs only to all members of one association and (B) does not  
24 market, offer, or sell any other individual, selected group, or group  
25 policy or contract providing medical, hospital, and surgical benefits  
26 shall not be required to market, offer, or sell to those who are not  
27 members of the association. However, if the carrier markets, offers,  
28 or sells any benefit plan design or any other individual, selected  
29 group, or group policy or contract providing medical, hospital, and  
30 surgical benefits to those who are not members of the association  
31 it is subject to the requirements of this section.

32 (6) Each carrier that sells health benefit plans to members of  
33 one association pursuant to paragraph (5) shall submit an annual  
34 statement to the commissioner which states that the carrier is selling  
35 health benefit plans pursuant to paragraph (5) and which, for the  
36 one association, lists all the information required by paragraph (7).

37 (7) Each carrier that sells health benefit plans to members of  
38 any association shall submit an annual statement to the  
39 commissioner which lists each association to which the carrier  
40 sells health benefit plans, the industry or profession which is served

1 by the association, the association's membership criteria, a list of  
2 officers, the state in which the association is organized, and the  
3 site of its principal office.

4 (8) For purposes of paragraphs (4) and (6), an association is a  
5 nonprofit organization comprised of a group of individuals or  
6 employers who associate based solely on participation in a  
7 specified profession or industry, accepting for membership any  
8 individual or small employer meeting its membership criteria,  
9 which do not condition membership directly or indirectly on the  
10 health or claims history of any person, which uses membership  
11 dues solely for and in consideration of the membership and  
12 membership benefits, except that the amount of the dues shall not  
13 depend on whether the member applies for or purchases insurance  
14 offered by the association, which is organized and maintained in  
15 good faith for purposes unrelated to insurance, which has been in  
16 active existence on January 1, 1992, and at least five years prior  
17 to that date, which has a constitution and bylaws, or other  
18 analogous governing documents which provide for election of the  
19 governing board of the association by its members, which has  
20 contracted with one or more carriers to offer one or more health  
21 benefit plans to all individual members and small employer  
22 members in this state. Health coverage through an association that  
23 is not related to employment shall be considered individual  
24 coverage pursuant to Section 144.102(c) of Title 45 of the Code  
25 of Federal Regulations.

26 (c) On and after October 1, 2013, each carrier shall make  
27 available to each small employer all health benefit plans that the  
28 carrier offers or sells to small employers or to associations that  
29 include small employers for plan years on or after January 1, 2014.  
30 Notwithstanding subdivision ~~(d)~~ (c) of Section 10753, for purposes  
31 of this subdivision, companies that are affiliated companies or that  
32 are eligible to file a consolidated income tax return shall be treated  
33 as one carrier.

34 (d) Each carrier shall do all of the following:

35 (1) Prepare a brochure that summarizes all of its health benefit  
36 plans and make this summary available to small employers, agents,  
37 and brokers upon request. The summary shall include for each  
38 plan information on benefits provided, a generic description of the  
39 manner in which services are provided, such as how access to  
40 providers is limited, benefit limitations, required copayments and

1 deductibles, ~~an explanation of how creditable coverage is calculated~~  
2 ~~if a waiting period is imposed~~, and a telephone number that can  
3 be called for more detailed benefit information. Carriers are  
4 required to keep the information contained in the brochure accurate  
5 and up to date, and, upon updating the brochure, send copies to  
6 agents and brokers representing the carrier. Any entity that provides  
7 administrative services only with regard to a health benefit plan  
8 written or issued by another carrier shall not be required to prepare  
9 a summary brochure which includes that benefit plan.

10 (2) For each health benefit plan, prepare a more detailed  
11 evidence of coverage and make it available to small employers,  
12 agents, and brokers upon request. The evidence of coverage shall  
13 contain all information that a prudent buyer would need to be aware  
14 of in making selections of benefit plan designs. An entity that  
15 provides administrative services only with regard to a health benefit  
16 plan written or issued by another carrier shall not be required to  
17 prepare an evidence of coverage for that health benefit plan.

18 (3) Provide copies of the current summary brochure to all agents  
19 or brokers who represent the carrier and, upon updating the  
20 brochure, send copies of the updated brochure to agents and brokers  
21 representing the carrier for the purpose of selling health benefit  
22 plans.

23 (4) Notwithstanding subdivision (c) of Section 10753, for  
24 purposes of this subdivision, companies that are affiliated  
25 companies or that are eligible to file a consolidated income tax  
26 return shall be treated as one carrier.

27 (e) Every agent or broker representing one or more carriers for  
28 the purpose of selling health benefit plans to small employers shall  
29 do all of the following:

30 (1) When providing information on a health benefit plan to a  
31 small employer but making no specific recommendations on  
32 particular benefit plan designs:

33 (A) Advise the small employer of the carrier's obligation to sell  
34 to any small employer any of the health benefit plans it offers to  
35 small employers, consistent with PPACA, and provide them, upon  
36 request, with the actual rates that would be charged to that  
37 employer for a given health benefit plan.

38 (B) Notify the small employer that the agent or broker will  
39 procure rate and benefit information for the small employer on

1 any health benefit plan offered by a carrier for whom the agent or  
2 broker sells health benefit plans.

3 (C) Notify the small employer that, upon request, the agent or  
4 broker will provide the small employer with the summary brochure  
5 required in paragraph (1) of subdivision (d) for any benefit plan  
6 design offered by a carrier whom the agent or broker represents.

7 (D) Notify the small employer of the availability of coverage  
8 and the availability of tax credits for certain employers consistent  
9 with PPACA and state law, including any rules, regulations, or  
10 guidance issued in connection therewith.

11 (2) When recommending a particular benefit plan design or  
12 designs, advise the small employer that, upon request, the agent  
13 will provide the small employer with the brochure required by  
14 paragraph (1) of subdivision (d) containing the benefit plan design  
15 or designs being recommended by the agent or broker.

16 (3) Prior to filing an application for a small employer for a  
17 particular health benefit plan:

18 (A) For each of the health benefit plans offered by the carrier  
19 whose health benefit plan the agent or broker is presenting, provide  
20 the small employer with the benefit summary required in paragraph  
21 (1) of subdivision (d) and the premium for that particular employer.

22 (B) Notify the small employer that, upon request, the agent or  
23 broker will provide the small employer with an evidence of  
24 coverage brochure for each health benefit plan the carrier offers.

25 (C) Obtain a signed statement from the small employer  
26 acknowledging that the small employer has received the disclosures  
27 required by this paragraph and Section 10753.16.

28 (f) No carrier, agent, or broker shall induce or otherwise  
29 encourage a small employer to separate or otherwise exclude an  
30 eligible employee from a health benefit plan which, in the case of  
31 an eligible employee meeting the definition in paragraph (1) of  
32 subdivision (f) of Section 10753, is provided in connection with  
33 the employee's employment or which, in the case of an eligible  
34 employee as defined in paragraph (2) of subdivision (f) of Section  
35 10753, is provided in connection with a guaranteed association.

36 (g) No carrier shall reject an application from a small employer  
37 for a health benefit plan provided:

38 (1) The small employer as defined by subparagraph (A) of  
39 paragraph (1) of subdivision (q) of Section 10753 offers health  
40 benefits to 100 percent of its eligible employees as defined in



1 paragraph (1) of subdivision (f) of Section 10753. Employees who  
2 waive coverage on the grounds that they have other group coverage  
3 shall not be counted as eligible employees.

4 (2) The small employer agrees to make the required premium  
5 payments.

6 (h) No carrier or agent or broker shall, directly or indirectly,  
7 engage in the following activities:

8 (1) Encourage or direct small employers to refrain from filing  
9 an application for coverage with a carrier because of the health  
10 status, claims experience, industry, occupation, or geographic  
11 location within the carrier's approved service area of the small  
12 employer or the small employer's employees.

13 (2) Encourage or direct small employers to seek coverage from  
14 another carrier because of the health status, claims experience,  
15 industry, occupation, or geographic location within the carrier's  
16 approved service area of the small employer or the small  
17 employer's employees.

18 (3) Employ marketing practices or benefit designs that will have  
19 the effect of discouraging the enrollment of individuals with  
20 significant health needs or discriminate based on the individual's  
21 race, color, national origin, present or predicted disability, age,  
22 sex, gender identity, sexual orientation, expected length of life,  
23 degree of medical dependency, quality of life, or other health  
24 conditions.

25 This subdivision shall be enforced in the same manner as Section  
26 790.03, including through Sections 790.035 and 790.05.

27 (i) No carrier shall, directly or indirectly, enter into any contract,  
28 agreement, or arrangement with an agent or broker that provides  
29 for or results in the compensation paid to an agent or broker for a  
30 health benefit plan to be varied because of the health status, claims  
31 experience, industry, occupation, or geographic location of the  
32 small employer or the small employer's employees. This  
33 subdivision shall not apply with respect to a compensation  
34 arrangement that provides compensation to an agent or broker on  
35 the basis of percentage of premium, provided that the percentage  
36 shall not vary because of the health status, claims experience,  
37 industry, occupation, or geographic area of the small employer.

38 (j) (1) A health benefit plan offered to a small employer, as  
39 defined in Section 1304(b) of PPACA and in Section 10753, shall  
40 not establish rules for eligibility, including continued eligibility,

1 of an individual, or dependent of an individual, to enroll under the  
2 terms of the plan based on any of the following health status-related  
3 factors:

- 4 (A) Health status.
- 5 (B) Medical condition, including physical and mental illnesses.
- 6 (C) Claims experience.
- 7 (D) Receipt of health care.
- 8 (E) Medical history.
- 9 (F) Genetic information.
- 10 (G) Evidence of insurability, including conditions arising out  
11 of acts of domestic violence.
- 12 (H) Disability.
- 13 (I) Any other health status-related factor as determined by any  
14 federal regulations, rules, or guidance issued pursuant to Section  
15 2705 of the federal Public Health Service Act.

16 (2) Notwithstanding Section 10291.5, a carrier shall not require  
17 an eligible employee or dependent to fill out a health assessment  
18 or medical questionnaire prior to enrollment under a health benefit  
19 plan. A carrier shall not acquire or request information that relates  
20 to a health status-related factor from the applicant or his or her  
21 dependent or any other source prior to enrollment of the individual.

22 (k) (1) A carrier shall consider as a single risk pool for rating  
23 purposes in the small employer market the claims experience of  
24 all insureds in all nongrandfathered small employer health benefit  
25 plans offered by the carrier in this state, whether offered as health  
26 care service plan contracts or health insurance policies, including  
27 those insureds and enrollees who enroll in coverage through the  
28 Exchange and insureds and enrollees covered by the carrier outside  
29 of the Exchange.

30 (2) At least each calendar year, and no more frequently than  
31 each calendar quarter, a carrier shall establish an index rate for the  
32 small employer market in the state based on the total combined  
33 claims costs for providing essential health benefits, as defined  
34 pursuant to Section 1302 of PPACA and Section 10112.27, within  
35 the single risk pool required under paragraph (1). The index rate  
36 shall be adjusted on a marketwide basis based on the total expected  
37 marketwide payments and charges under the risk adjustment and  
38 reinsurance programs established for the state pursuant to Sections  
39 1343 and 1341 of PPACA *and Exchange user fees, as described*  
40 *in subdivision (d) of Section 156.80 of Title 45 of the Code of*

*Federal Regulations.* The premium rate for all of the carrier's nongrandfathered health benefit plans shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A carrier may vary premium rates for a particular nongrandfathered health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for health benefit plans that offer those benefits in addition to essential health benefits.

(D) Administrative costs, excluding any user fees required by the Exchange.

(E) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(f) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case, 12 months after the repeal, carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

(2) Paragraph (3) of subdivision (b) of this section shall remain operative as it relates to health benefit plans offered through the Exchange.

SEC. 12. Section 10753.08 of the Insurance Code is repealed.

SEC. 13. Section 10753.08 is added to the Insurance Code, to read:

10753.08. A health benefit plan shall not impose a preexisting condition provision or a waiting or affiliation period upon any individual.

SEC. 14. Section 10755 of the Insurance Code is amended to read:

10755. As used in this chapter, the following definitions shall apply:

(a) “Agent or broker” means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) “Carrier” means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder.

(d) “Dependent” means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (t).

(e) “Eligible employee” means either of the following:

1 (1) Any permanent employee who is actively engaged on a  
2 full-time basis in the conduct of the business of the small employer  
3 with a normal workweek of an average of 30 hours per week over  
4 the course of a month, in the small employer's regular place of  
5 business, who has met any statutorily authorized applicable waiting  
6 period requirements. The term includes sole proprietors or partners  
7 of a partnership, if they are actively engaged on a full-time basis  
8 in the small employer's business, and they are included as  
9 employees under a health benefit plan of a small employer, but  
10 does not include employees who work on a part-time, temporary,  
11 or substitute basis. It includes any eligible employee, as defined  
12 in this paragraph, who obtains coverage through a guaranteed  
13 association. Employees of employers purchasing through a  
14 guaranteed association shall be deemed to be eligible employees  
15 if they would otherwise meet the definition except for the number  
16 of persons employed by the employer. A permanent employee  
17 who works at least 20 hours but not more than 29 hours is deemed  
18 to be an eligible employee if all four of the following apply:

19 (A) The employee otherwise meets the definition of an eligible  
20 employee except for the number of hours worked.

21 (B) The employer offers the employee health coverage under a  
22 health benefit plan.

23 (C) All similarly situated individuals are offered coverage under  
24 the health benefit plan.

25 (D) The employee must have worked at least 20 hours per  
26 normal workweek for at least 50 percent of the weeks in the  
27 previous calendar quarter. The insurer may request any necessary  
28 information to document the hours and time period in question,  
29 including, but not limited to, payroll records and employee wage  
30 and tax filings.

31 (2) Any member of a guaranteed association as defined in  
32 subdivision (t).

33 (f) "Enrollee" means an eligible employee or dependent who  
34 receives health coverage through the program from a participating  
35 carrier.

36 (g) "Financially impaired" means, for the purposes of this  
37 chapter, a carrier that, on or after the effective date of this chapter,  
38 is not insolvent and is either:

39 (1) Deemed by the commissioner to be potentially unable to  
40 fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(h) “Health benefit plan” means a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(i) “In force business” means an existing health benefit plan issued by the carrier to a small employer.

(j) “Late enrollee” means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association’s health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (t), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, the Medi-Cal program, or coverage through the California Health Benefit Exchange at the time the individual was eligible to enroll.

1 (B) He or she certified at the time of the initial enrollment that  
2 coverage under another employer health benefit plan, the Healthy  
3 Families Program, the AIM Program, the Medi-Cal program, or  
4 the California Health Benefit Exchange was the reason for  
5 declining enrollment provided that, if the individual was covered  
6 under another employer health plan, the individual was given the  
7 opportunity to make the certification required by this subdivision  
8 and was notified that failure to do so could result in later treatment  
9 as a late enrollee.

10 (C) He or she has lost or will lose coverage under another  
11 employer health benefit plan as a result of termination of  
12 employment of the individual or of a person through whom the  
13 individual was covered as a dependent, change in employment  
14 status of the individual, or of a person through whom the individual  
15 was covered as a dependent, the termination of the other plan's  
16 coverage, cessation of an employer's contribution toward an  
17 employee or dependent's coverage, death of the person through  
18 whom the individual was covered as a dependent, legal separation,  
19 or divorce; or he or she has lost or will lose coverage under the  
20 Healthy Families Program, the AIM Program, the Medi-Cal  
21 program, or the California Health Benefit Exchange.

22 (D) He or she requests enrollment within 30 days after  
23 termination of coverage or employer contribution toward coverage  
24 provided under another employer health benefit plan, or requests  
25 enrollment within 60 days after termination of Medi-Cal program  
26 coverage, AIM Program coverage, Healthy Families Program  
27 coverage, or coverage offered through the California Health Benefit  
28 Exchange.

29 (2) The individual is employed by an employer who offers  
30 multiple health benefit plans and the individual elects a different  
31 plan during an open enrollment period.

32 (3) A court has ordered that coverage be provided for a spouse  
33 or minor child under a covered employee's health benefit plan.

34 (4) (A) In the case of an eligible employee as defined in  
35 paragraph (1) of subdivision (e), the carrier cannot produce a  
36 written statement from the employer stating that the individual or  
37 the person through whom an individual was eligible to be covered  
38 as a dependent, prior to declining coverage, was provided with,  
39 and signed acknowledgment of, an explicit written notice in  
40 boldface type specifying that failure to elect coverage during the

1 initial enrollment period permits the carrier to impose, at the time  
2 of the individual's later decision to elect coverage, an exclusion  
3 from ~~coverage for a period of 12 months~~ *eligibility for coverage*  
4 *until the next open enrollment period*, unless the individual meets  
5 the criteria specified in paragraph (1), (2), or (3). This exclusion  
6 from *eligibility for coverage* shall not be considered a waiting  
7 period in violation of Section 10198.7 or 10755.08.

8 (B) In the case of an eligible employee who is a guaranteed  
9 association member, the plan cannot produce a written statement  
10 from the guaranteed association stating that the association sent a  
11 written notice in boldface type to all potentially eligible association  
12 members at their last known address prior to the initial enrollment  
13 period informing members that failure to elect coverage during  
14 the initial enrollment period permits the plan to impose, at the time  
15 of the member's later decision to elect coverage, an exclusion from  
16 ~~coverage for a period of 12 months~~ *eligibility for coverage until*  
17 *the next open enrollment period*, unless the member can  
18 demonstrate that he or she meets the requirements of subparagraphs  
19 (A), (C), and (D) of paragraph (1) or meets the requirements of  
20 paragraph (2) or (3). This exclusion from *eligibility for coverage*  
21 shall not be considered a waiting period in violation of Section  
22 10198.7 or 10755.08.

23 (C) In the case of an employer or person who is not a member  
24 of an association, was eligible to purchase coverage through a  
25 guaranteed association, and did not do so, and would not be eligible  
26 to purchase guaranteed coverage unless purchased through a  
27 guaranteed association, the employer or person can demonstrate  
28 that he or she meets the requirements of subparagraphs (A), (C),  
29 and (D) of paragraph (1), or meets the requirements of paragraph  
30 (2) or (3), or that he or she recently had a change in status that  
31 would make him or her eligible and that application for coverage  
32 was made within 30 days of the change.

33 (5) The individual is an employee or dependent who meets the  
34 criteria described in paragraph (1) and was under a COBRA  
35 continuation provision and the coverage under that provision has  
36 been exhausted. For purposes of this section, the definition of  
37 "COBRA" set forth in subdivision (e) of Section 10116.5 shall  
38 apply.

39 (6) The individual is a dependent of an enrolled eligible  
40 employee who has lost or will lose his or her coverage under the



1 Healthy Families Program, the AIM Program, the Medi-Cal  
2 program, or the California Health Benefit Exchange and requests  
3 enrollment within 60 days after termination of that coverage.

4 (7) The individual is an eligible employee who previously  
5 declined coverage under an employer health benefit plan, including  
6 a plan offered through the California Health Benefit Exchange,  
7 and who has subsequently acquired a dependent who would be  
8 eligible for coverage as a dependent of the employee through  
9 marriage, birth, adoption, or placement for adoption, and who  
10 enrolls for coverage under that employer health benefit plan on  
11 his or her behalf and on behalf of his or her dependent within 30  
12 days following the date of marriage, birth, adoption, or placement  
13 for adoption, in which case the effective date of coverage shall be  
14 the first day of the month following the date the completed request  
15 for enrollment is received in the case of marriage, or the date of  
16 birth, or the date of adoption or placement for adoption, whichever  
17 applies. Notice of the special enrollment rights contained in this  
18 paragraph shall be provided by the employer to an employee at or  
19 before the time the employee is offered an opportunity to enroll  
20 in plan coverage.

21 (8) The individual is an eligible employee who has declined  
22 coverage for himself or herself or his or her dependents during a  
23 previous enrollment period because his or her dependents were  
24 covered by another employer health benefit plan, including a plan  
25 offered through the California Health Benefit Exchange, at the  
26 time of the previous enrollment period. That individual may enroll  
27 himself or herself or his or her dependents for plan coverage during  
28 a special open enrollment opportunity if his or her dependents have  
29 lost or will lose coverage under that other employer health benefit  
30 plan. The special open enrollment opportunity shall be requested  
31 by the employee not more than 30 days after the date that the other  
32 health coverage is exhausted or terminated. Upon enrollment,  
33 coverage shall be effective not later than the first day of the first  
34 calendar month beginning after the date the request for enrollment  
35 is received. Notice of the special enrollment rights contained in  
36 this paragraph shall be provided by the employer to an employee  
37 at or before the time the employee is offered an opportunity to  
38 enroll in plan coverage.

39 (k) “Preexisting condition provision” means a policy provision  
40 that excludes coverage for charges or expenses incurred during a

1 specified period following the insured's effective date of coverage,  
2 as to a condition for which medical advice, diagnosis, care, or  
3 treatment was recommended or received during a specified period  
4 immediately preceding the effective date of coverage.

5 (l) "Creditable coverage" means:

6 (1) Any individual or group policy, contract, or program, that  
7 is written or administered by a disability insurer, health care service  
8 plan, fraternal benefits society, self-insured employer plan, or any  
9 other entity, in this state or elsewhere, and that arranges or provides  
10 medical, hospital, and surgical coverage not designed to supplement  
11 other private or governmental plans. The term includes continuation  
12 or conversion coverage but does not include accident only, credit,  
13 coverage for onsite medical clinics, disability income, Medicare  
14 supplement, long-term care, dental, vision, coverage issued as a  
15 supplement to liability insurance, insurance arising out of a  
16 workers' compensation or similar law, automobile medical payment  
17 insurance, or insurance under which benefits are payable with or  
18 without regard to fault and that is statutorily required to be  
19 contained in any liability insurance policy or equivalent  
20 self-insurance.

21 (2) The federal Medicare Program pursuant to Title XVIII of  
22 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

23 (3) The Medicaid Program pursuant to Title XIX of the federal  
24 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

25 (4) Any other publicly sponsored program, provided in this state  
26 or elsewhere, of medical, hospital, and surgical care.

27 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
28 (Civilian Health and Medical Program of the Uniformed Services  
29 (CHAMPUS)).

30 (6) A medical care program of the Indian Health Service or of  
31 a tribal organization.

32 (7) A health plan offered under 5 U.S.C. Chapter 89  
33 (commencing with Section 8901) (Federal Employees Health  
34 Benefits Program (FEHBP)).

35 (8) A public health plan as defined in federal regulations  
36 authorized by Section 2701(c)(1)(I) of the federal Public Health  
37 Service Act, as amended by Public Law 104-191, the federal Health  
38 Insurance Portability and Accountability Act of 1996.

39 (9) A health benefit plan under Section 5(e) of the federal Peace  
40 Corps Act (22 U.S.C. Sec. 2504(e)).

(10) Any other creditable coverage as defined by subdivision (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(m) “Rating period” means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months from the date of issuance or renewal of the health benefit plan.

(n) “Risk adjusted employee risk rate” means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(o) “Risk adjustment factor” means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 110 percent or less than 90 percent.

(p) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple or registered domestic partners.

(C) One adult and child or children.

(D) Married couple or registered domestic partners and child or children.

(3) (A) In determining rates for small employers, a carrier that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and shall divide no county into more than two regions. Carriers shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties which are included in their entirety in a carrier's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No carrier shall have less than one geographic area.

(q) (1) "Small employer" means either of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50

1 percent of its working days during the preceding calendar quarter  
2 or preceding calendar year, employed at least one, but no more  
3 than 100, eligible employees, the majority of whom were employed  
4 within this state, that was not formed primarily for purposes of  
5 buying health benefit plans, and in which a bona fide  
6 employer-employee relationship exists. In determining whether  
7 to apply the calendar quarter or calendar year test, a carrier shall  
8 use the test that ensures eligibility if only one test would establish  
9 eligibility. In determining the number of eligible employees,  
10 companies that are affiliated companies and that are eligible to file  
11 a combined tax return for purposes of state taxation shall be  
12 considered one employer. Subsequent to the issuance of a health  
13 benefit plan to a small employer pursuant to this chapter, and for  
14 the purpose of determining eligibility, the size of a small employer  
15 shall be determined annually. Except as otherwise specifically  
16 provided in this chapter, provisions of this chapter that apply to a  
17 small employer shall continue to apply until the plan contract  
18 anniversary following the date the employer no longer meets the  
19 requirements of this definition. It includes any small employer as  
20 defined in this subparagraph who purchases coverage through a  
21 guaranteed association, and any employer purchasing coverage  
22 for employees through a guaranteed association. This subparagraph  
23 shall be implemented to the extent consistent with PPACA, except  
24 that the minimum requirement of one employee shall be  
25 implemented only to the extent required by PPACA.

26 (B) Any guaranteed association, as defined in subdivision (s),  
27 that purchases health coverage for members of the association.

28 (2) For plan years commencing on or after January 1, 2014, the  
29 definition of an employer, for purposes of determining whether  
30 an employer with one employee shall include sole proprietors,  
31 certain owners of “S” corporations, or other individuals, shall be  
32 consistent with Section 1304 of PPACA.

33 (r) “Standard employee risk rate” means the rate applicable to  
34 an eligible employee in a particular risk category in a small  
35 employer group.

36 (s) “Guaranteed association” means a nonprofit organization  
37 comprised of a group of individuals or employers who associate  
38 based solely on participation in a specified profession or industry,  
39 accepting for membership any individual or employer meeting its  
40 membership criteria which (1) includes one or more small

1 employers as defined in subparagraph (A) of paragraph (1) of  
2 subdivision (q), (2) does not condition membership directly or  
3 indirectly on the health or claims history of any person, (3) uses  
4 membership dues solely for and in consideration of the membership  
5 and membership benefits, except that the amount of the dues shall  
6 not depend on whether the member applies for or purchases  
7 insurance offered by the association, (4) is organized and  
8 maintained in good faith for purposes unrelated to insurance, (5)  
9 has been in active existence on January 1, 1992, and for at least  
10 five years prior to that date, (6) has been offering health insurance  
11 to its members for at least five years prior to January 1, 1992, (7)  
12 has a constitution and bylaws, or other analogous governing  
13 documents that provide for election of the governing board of the  
14 association by its members, (8) offers any benefit plan design that  
15 is purchased to all individual members and employer members in  
16 this state, (9) includes any member choosing to enroll in the benefit  
17 plan design offered to the association provided that the member  
18 has agreed to make the required premium payments, and (10)  
19 covers at least 1,000 persons with the carrier with which it  
20 contracts. The requirement of 1,000 persons may be met if  
21 component chapters of a statewide association contracting  
22 separately with the same carrier cover at least 1,000 persons in the  
23 aggregate.

24 This subdivision applies regardless of whether a master policy  
25 by an admitted insurer is delivered directly to the association or a  
26 trust formed for or sponsored by an association to administer  
27 benefits for association members.

28 For purposes of this subdivision, an association formed by a  
29 merger of two or more associations after January 1, 1992, and  
30 otherwise meeting the criteria of this subdivision shall be deemed  
31 to have been in active existence on January 1, 1992, if its  
32 predecessor organizations had been in active existence on January  
33 1, 1992, and for at least five years prior to that date and otherwise  
34 met the criteria of this subdivision.

35 (t) "Members of a guaranteed association" means any individual  
36 or employer meeting the association's membership criteria if that  
37 person is a member of the association and chooses to purchase  
38 health coverage through the association. At the association's  
39 discretion, it may also include employees of association members,  
40 association staff, retired members, retired employees of members,

1 and surviving spouses and dependents of deceased members.  
2 However, if an association chooses to include those persons as  
3 members of the guaranteed association, the association must so  
4 elect in advance of purchasing coverage from a plan. Health plans  
5 may require an association to adhere to the membership  
6 composition it selects for up to 12 months.

7 (u) “Grandfathered health benefit plan” means a health benefit  
8 plan that constitutes a grandfathered health plan.

9 (v) “Grandfathered health plan” has the meaning set forth in  
10 Section 1251 of PPACA.

11 (w) “Nongrandfathered health benefit plan” means a health  
12 benefit plan that is not a grandfathered health plan.

13 (x) “Plan year” has the meaning set forth in Section 144.103 of  
14 Title 45 of the Code of Federal Regulations.

15 (y) “PPACA” means the federal Patient Protection and  
16 Affordable Care Act (Public Law 111-148), as amended by the  
17 federal Health Care and Education Reconciliation Act of 2010  
18 (Public Law 111-152), and any rules, regulations, or guidance  
19 issued thereunder.

20 (z) “Waiting period” means a period that is required to pass  
21 with respect to the employee before the employee is eligible to be  
22 covered for benefits under the terms of the contract.

23 (aa) “Registered domestic partner” means a person who has  
24 established a domestic partnership as described in Section 297 of  
25 the Family Code.

26 SEC. 15. Section 10755.05 of the Insurance Code is amended  
27 to read:

28 10755.05. (a) (1) Each carrier, except a self-funded employer,  
29 shall fairly and affirmatively renew all of the carrier’s health benefit  
30 plans that are sold to small employers or associations that include  
31 small employers.

32 (2) Nothing in this section shall be construed to require an  
33 association, or a trust established and maintained by an association  
34 to receive a master insurance policy issued by an admitted insurer  
35 and to administer the benefits thereof solely for association  
36 members, to offer, market or sell a benefit plan design to those  
37 who are not members of the association. However, if the  
38 association markets, offers or sells a benefit plan design to those  
39 who are not members of the association it is subject to the  
40 requirements of this section. This shall apply to an association that

1 otherwise meets the requirements of paragraph (6) formed by  
2 merger of two or more associations after January 1, 1992, if the  
3 predecessor organizations had been in active existence on January  
4 1, 1992, and for at least five years prior to that date and met the  
5 requirements of paragraph (3).

6 (3) A carrier which (A) effective January 1, 1992, and at least  
7 20 years prior to that date, markets, offers, or sells benefit plan  
8 designs only to all members of one association and (B) does not  
9 market, offer or sell any other individual, selected group, or group  
10 policy or contract providing medical, hospital and surgical benefits  
11 shall not be required to market, offer, or sell to those who are not  
12 members of the association. However, if the carrier markets, offers  
13 or sells any benefit plan design or any other individual, selected  
14 group, or group policy or contract providing medical, hospital and  
15 surgical benefits to those who are not members of the association  
16 it is subject to the requirements of this section.

17 (4) Each carrier that sells health benefit plans to members of  
18 one association pursuant to paragraph (3) shall submit an annual  
19 statement to the commissioner which states that the carrier is selling  
20 health benefit plans pursuant to paragraph (3) and which, for the  
21 one association, lists all the information required by paragraph (5).

22 (5) Each carrier that sells health benefit plans to members of  
23 any association shall submit an annual statement to the  
24 commissioner which lists each association to which the carrier  
25 sells health benefit plans, the industry or profession which is served  
26 by the association, the association's membership criteria, a list of  
27 officers, the state in which the association is organized, and the  
28 site of its principal office.

29 (6) For purposes of paragraphs (2) and (3), an association is a  
30 nonprofit organization comprised of a group of individuals or  
31 employers who associate based solely on participation in a  
32 specified profession or industry, accepting for membership any  
33 individual or small employer meeting its membership criteria,  
34 which do not condition membership directly or indirectly on the  
35 health or claims history of any person, which uses membership  
36 dues solely for and in consideration of the membership and  
37 membership benefits, except that the amount of the dues shall not  
38 depend on whether the member applies for or purchases insurance  
39 offered by the association, which is organized and maintained in  
40 good faith for purposes unrelated to insurance, which has been in



1 active existence on January 1, 1992, and at least five years prior  
2 to that date, which has a constitution and bylaws, or other  
3 analogous governing documents which provide for election of the  
4 governing board of the association by its members, which has  
5 contracted with one or more carriers to offer one or more health  
6 benefit plans to all individual members and small employer  
7 members in this state.

8 (b) Each carrier shall make available to each small employer  
9 all nongrandfathered health benefit plans that the carrier offers or  
10 sells to small employers or to associations that include small  
11 employers. Notwithstanding subdivision (c) of Section 10755, for  
12 purposes of this subdivision, companies that are affiliated  
13 companies or that are eligible to file a consolidated income tax  
14 return shall be treated as one carrier.

15 (c) Each carrier shall do all of the following:

16 (1) Prepare a brochure that summarizes all of its health benefit  
17 plans and make this summary available to small employers, agents,  
18 and brokers upon request. The summary shall include for each  
19 health benefit plan information on benefits provided, a generic  
20 description of the manner in which services are provided, such as  
21 how access to providers is limited, benefit limitations, required  
22 copayments and deductibles, standard employee risk rates, and a  
23 telephone number that can be called for more detailed benefit  
24 information. Carriers are required to keep the information contained  
25 in the brochure accurate and up to date, and, upon updating the  
26 brochure, send copies to agents and brokers representing the carrier.  
27 Any entity that provides administrative services only with regard  
28 to a benefit plan design written or issued by another carrier shall  
29 not be required to prepare a summary brochure which includes  
30 that benefit plan design.

31 (2) For each health benefit plan, prepare a more detailed  
32 evidence of coverage and make it available to small employers,  
33 agents and brokers upon request. The evidence of coverage shall  
34 contain all information that a prudent buyer would need to be aware  
35 of in making selections of benefit plan designs. An entity that  
36 provides administrative services only with regard to a benefit plan  
37 design written or issued by another carrier shall not be required to  
38 prepare an evidence of coverage for that benefit plan design.

39 (3) Provide to small employers and agents and brokers, upon  
40 request, for any given small employer the sum of the standard

1 employee risk rates and the sum of the risk adjusted employee risk  
2 rates. When requesting this information, small employers and  
3 agents and brokers shall provide the plan with the information the  
4 plan needs to determine the small employer's risk adjusted  
5 employee risk rate.

6 (4) Provide copies of the current summary brochure to all agents  
7 or brokers who represent the carrier and, upon updating the  
8 brochure, send copies of the updated brochure to agents and brokers  
9 representing the carrier for the purpose of selling health benefit  
10 plans.

11 (5) Notwithstanding subdivision (c) of Section 10755, for  
12 purposes of this subdivision, companies that are affiliated  
13 companies or that are eligible to file a consolidated income tax  
14 return shall be treated as one carrier.

15 (d) No carrier, agent, or broker shall induce or otherwise  
16 encourage a small employer to separate or otherwise exclude an  
17 eligible employee from a health benefit plan which, in the case of  
18 an eligible employee meeting the definition in paragraph (1) of  
19 subdivision (e) of Section 10755, is provided in connection with  
20 the employee's employment or which, in the case of an eligible  
21 employee as defined in paragraph (2) of subdivision (e) of Section  
22 10755, is provided in connection with a guaranteed association.

23 (e) No carrier or agent or broker shall, directly or indirectly,  
24 engage in the following activities:

25 (1) Encourage or direct small employers to refrain from filing  
26 an application for coverage with a carrier because of the health  
27 status, claims experience, industry, occupation, or geographic  
28 location within the carrier's approved service area of the small  
29 employer or the small employer's employees.

30 (2) Encourage or direct small employers to seek coverage from  
31 another carrier or the California Health Benefit Exchange because  
32 of the health status, claims experience, industry, occupation, or  
33 geographic location within the carrier's approved service area of  
34 the small employer or the small employer's employees.

35 (f) No carrier shall, directly or indirectly, enter into any contract,  
36 agreement, or arrangement with an agent or broker that provides  
37 for or results in the compensation paid to an agent or broker for a  
38 health benefit plan to be varied because of the health status, claims  
39 experience, industry, occupation, or geographic location of the  
40 small employer or the small employer's employees. This

subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(g) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in subdivision (q) of Section 10755 shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

- (1) Health status.
- (2) Medical condition, including physical and mental illnesses.
- (3) Claims experience.
- (4) Receipt of health care.
- (5) Medical history.
- (6) Genetic information.
- (7) Evidence of insurability, including conditions arising out of acts of domestic violence.
- (8) Disability.
- (9) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(h) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

SEC. 16. Section 10755.08 of the Insurance Code is repealed.

SEC. 17. Section 10755.08 is added to the Insurance Code, to read:

10755.08. A health benefit plan shall not impose a preexisting condition provision or a waiting or affiliation period upon any individual.

SEC. 18. *Section 11.5 of this bill incorporates amendments to Section 10753.05 of the Insurance Code proposed by both this bill and SB 959. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2015, (2) each bill amends Section 10753.05 of the Insurance Code, and (3)*

1 *this bill is enacted after SB 959, in which case Section 11 of this*  
2 *bill shall not become operative.*

3 ~~SEC. 18.~~

4 *SEC. 19.* No reimbursement is required by this act pursuant to  
5 Section 6 of Article XIII B of the California Constitution because  
6 the only costs that may be incurred by a local agency or school  
7 district will be incurred because this act creates a new crime or  
8 infraction, eliminates a crime or infraction, or changes the penalty  
9 for a crime or infraction, within the meaning of Section 17556 of  
10 the Government Code, or changes the definition of a crime within  
11 the meaning of Section 6 of Article XIII B of the California  
12 Constitution.